14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: **1/26/2015**

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left 11 intercostal nerve block with Fluoroscopy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

D.O. Board Certified in Anesthesiology and Pain Management**.**

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a female who was injured at work on xx/xx/xx. Patient main complaint is mid thoracic more to the left side under the shoulder blade. Patient has been treated with nonsteroidal anti-inflammatory, Voltaren gel, physical therapy, muscle relaxant, also patient had left rib x-ray (normal), x-ray thoracic spine(normal), MRI of thoracic spine(normal), total body bone imaging(normal). On physical exam patient's pain level is 4/10, most of her pain in the left lower thoracic and flank region.

ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS,

It has been 10 months since the time of injury on xx/xx/xx and the patient's chief complaint still aching pain in the middle of her back (note on 2/10/2014), also in this note stated that the patient has not reached maximum medical improvement at this time. Based on the medical records provided for review and test results the Intercostal nerve block one time only is reasonable for this patient's pain.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES